TRANSAMERICA WORKSITE MARKETING

Transamerica Worksite Marketing
P.O. Box 8043
Little Rock, AR 72203-8043
1-800-251-7254
7 a.m. – 5 p.m. CST
Fax: 866-586-6528

Disability Benefits Claim Form

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

Employee's Statement

1. Full Name	2. Date of Birth	3. Certificate Number	4. Phone Number

5. Address (*include city, state and zip code)*	6. Social Security Number

7. Date accident or illness began	8. Nature of illness or injury:

9. If accident, where and how did it happen?	10. Have you been confined to a hospital for this condition? ☐ Yes ☐ No If yes, Admitted: Discharged:

11. Have you ever had or been treated for the same or similar condition? ☐ Yes ☐ No

If yes, when and please describe _____

12. Name and address of hospital(s)

_____

13. Name and address of doctor(s)

_____

14. Last date worked	15. On what date did you return to work? ☐ Full time ☐ Part time	16. If you have not returned to work, date you anticipate returning to work?

Identify any other sources and amount of income for which you are receiving or for which you may be eligible. This listing should include any other Group Disability Income Coverage, Social Security Benefits, Group Pension Benefits, Worker's Compensation, Salary Continuance, Veteran's Administration Benefits, any retirement, etc.

		Effective			Effective
Your Social Security	☐ Yes ☐ No $_____	Mo._____	V.A. Benefits	☐ Yes ☐ No $_____	Mo._____
Dependent, Social Security	☐ Yes ☐ No $_____	Mo._____	Railroad Retirement	☐ Yes ☐ No $_____	Mo._____
Worker's Compensation	☐ Yes ☐ No $_____	Mo._____	Other Disability Coverage	☐ Yes ☐ No $_____	Mo._____
Retirement	☐ Yes ☐ No $_____	Mo._____	Other (Identify)	☐ Yes ☐ No $_____	Mo._____

TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY
TRANSAMERICA LIFE INSURANCE COMPANY
MONUMENTAL LIFE INSURANCE COMPANY
LIFE INVESTORS INSURANCE COMPANY OF AMERICA

The information above is true and correct to the best of my knowledge.

Claimant's Signature: _____ Date: _____

Employer's Statement

Company Name	Address	Phone #
		( )

Name of Employee

Was employee covered by the previous carrier? _____
Effective date: _____
Benefit amount: _____

Does this employee contribute to Social Security? ☐ Yes ☐ No
If No, was the employee hired after 4/1/86? ☐ Yes ☐ No

The percentage of the employee's Disability Premium you pay _____%

Is the Disability Premium paid by the Employee? ☐ Yes ☐ No
If yes, ☐ Before or ☐ After taxes?

Employee's Title:	Annual Salary:

Is this loss a result of employment? ☐ Yes ☐ No

Has the employee made claim for or is he/she entitled to Workers' Compensation? ☐ Yes ☐ No

Date employee last worked?	Date returned to work? ☐ Full time ☐ Part time	If Part time, due to Partial Disability, give weekly earnings: $

Give amount of time of paid sick leave to which employee is entitled: (Indicate type: PTO, EIB, etc.)

At the time of disability was the employee: ☐ Full-Time ☐ Part-Time ☐ On-Leave ☐ Retired ☐ No Longer Employed (Check one)?

Is employee eligible for any other paid compensation? ☐ Yes ☐ No If Yes, explain what type of benefit this is:

Monthly Benefit Amount: Period eligible:

Signature of Employer Representative	Title	Date

Attending Physician's Statement

Patient Name	Account #	SS #

1. Diagnosis and concurrent condition — ICDA Code

2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

3. Pregnancy? ☐ Yes ☐ No
If yes, what is the expected delivery date?

4. Dates of services since disability commenced
_____
_____

5. Was patient hospitalized ☐ Yes ☐ No
Name of Hospital?_____
Address:_____
Admitted Discharged

6. Date symptoms first appeared or accident happened?

7. Date patient first consulted you for this condition?

8. Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, when and describe:

9. Is patient still under your care for this condition ☐ Yes ☐ No

10. Patient was totally disabled (unable to work)?
From To

11. Patient was partially disabled?
From To

12. If still disabled, date patient should be able to return to work

13. Was the patient referred to you ☐ Yes ☐ No
If yes, what is the referring physicians name & address?

Physician's Name (print) _____ Date _____

Signature _____ Degree _____

Address _____
Street City State Zip

Phone Number _____ Tax Identification Number _____

ADDENDUM TO CLAIM FORM

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim form.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

_____
Claimant's Signature Date

FOR RESIDENTS OF ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

_____
Claimant's Signature Date

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____
Claimant's Signature Date

FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

_____
Claimant's Signature Date

FOR RESIDENTS OF DELEWARE, IDAHO or INDIANA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

_____
Claimant's Signature Date

FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____
Claimant's Signature Date

FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

_____
Claimant's Signature Date

FOR RESIDENTS OF LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____
Claimant's Signature Date

FOR RESIDENTS OF MARYLAND: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false and/or deceptive statement is guilty of insurance fraud.

_____
Claimant's Signature Date

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

_____
Claimant's Signature Date

FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

_____
Claimant's Signature Date

FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

_____
Claimant's Signature Date

FOR RESIDENTS OF OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or conceals, for the purpose of misleading, any information concerning a fact material thereto, may be guilty of insurance fraud.

_____
Claimant's Signature Date

FOR RESIDENTS OF VIRGINIA or TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

_____
Claimant's Signature Date

FOR RESIDENTS OF ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____
Claimant's Signature Date

TRANSAMERICA
WORKSITE MARKETING

Name of Insurance Company (select one):
- ❑ Transamerica Life Insurance Company
- ❑ Transamerica Occidental Life Insurance Company
- ❑ Monumental Life Insurance Company
- ❑ Life Investors Insurance Company of America

If no Company is selected, the appropriate box will be checked by at the Administrative Office.

Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.

2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.

3. **Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. **Exception: psychotherapy notes require a separate signed authorization.**

4. **The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.

Patient/Insured's Name/Signature:	_____	Date	_____
Personal Representative's (if any) Name/Signature:	_____	Patient/ Insured's SSN	_____
Patient/Insured's Address:	_____	Patient/ Insured's Date of Birth	_____
Personal Representative's (if any) Address	_____	Personal Representative's Phone Number	_____
Description of Personal Representative's Authority or Relationship to Patient/Insured	_____		